		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026765

Facility Name: Burgin Manor of Olney, Inc.

Address: 928 East Scott (Number) Olney (City) 62450 (Zip Code)

County: Richland

Telephone Number: 618-395-1000 **Fax #** 618-392-2150

IDPA ID Number: 37-1116643001

Date of Initial License for Current Owners: 4/20/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ken Marx **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 09/10/2004

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	156	56,843	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	156	56,843	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,880	21,206	3,097	52,183	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,880	21,206	3,097	52,183	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.80%

D. How many bed-hold days during this year were paid by Public Aid? ____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 4/20/82

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 4/20/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 156 and days of care provided 3,097

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	279,539	21,464	12,068	313,071	5,158	318,229		318,229			1
2	Food Purchase		268,934		268,934	(6,344)	262,590		262,590			2
3	Housekeeping	104,423	26,724		131,147		131,147		131,147			3
4	Laundry	81,179	5,987	3,783	90,949		90,949		90,949			4
5	Heat and Other Utilities			108,448	108,448		108,448		108,448			5
6	Maintenance	62,608	17,452	93,307	173,367		173,367	568	173,935			6
7	Other (specify):*											7
8	**TOTAL General Services**	527,749	340,561	217,606	1,085,916	(1,186)	1,084,730	568	1,085,298			8
	B. Health Care and Programs											
9	Medical Director			7,100	7,100		7,100		7,100			9
10	Nursing and Medical Records	1,907,382	142,909	113,875	2,164,166	5,158	2,169,324		2,169,324			10
10a	Therapy	35,794	1,580	444,769	482,143		482,143		482,143			10a
11	Activities											11
12	Social Services	128,060	3,564	5,241	136,865		136,865		136,865			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,071,236	148,053	570,985	2,790,274	5,158	2,795,432		2,795,432			16
	C. General Administration											
17	Administrative	95,069		187,189	282,258	95,069	377,327	(36,066)	341,261			17
18	Directors Fees											18
19	Professional Services			23,794	23,794		23,794		23,794			19
20	Dues, Fees, Subscriptions & Promotions			12,065	12,065		12,065	(319)	11,746			20
21	Clerical & General Office Expenses	86,135	13,135	40,894	140,164	(93,347)	46,817	5,313	52,130			21
22	Employee Benefits & Payroll Taxes			613,348	613,348	6,344	619,692		619,692			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,823	1,823		1,823		1,823			24
25	Other Admin. Staff Transportation			15,454	15,454		15,454		15,454			25
26	Insurance-Prop.Liab.Malpractice			112,870	112,870		112,870		112,870			26
27	Other (specify):*							2,000	2,000			27
28	**TOTAL General Administration**	181,204	13,135	1,007,437	1,201,776	8,066	1,209,842	(29,072)	1,180,770			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,780,189	501,749	1,796,028	5,077,966	12,038	5,090,004	(28,504)	5,061,500			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Burgin Manor of Olney, Inc. #0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			119,268	119,268		119,268	46,684	165,952			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			126,944	126,944		126,944	(10,467)	116,477			32
33	Real Estate Taxes			69,221	69,221		69,221		69,221			33
34	Rent-Facility & Grounds							9,079	9,079			34
35	Rent-Equipment & Vehicles			19,207	19,207		19,207		19,207			35
36	Other (specify):*											36
37	**TOTAL Ownership**			334,640	334,640		334,640	45,296	379,936			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			6,772	6,772	5,158	11,930		11,930			39
40	Barber and Beauty Shops			27,523	27,523		27,523		27,523			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,266	85,266		85,266		85,266			42
43	Other (specify):* **Sales Tax**			79,222	79,222	(17,196)	62,026	(85,964)	(23,938)			43
44	**TOTAL Special Cost Centers**			198,783	198,783	(12,038)	186,745	(85,964)	100,781			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,780,189	501,749	2,329,451	5,611,389		5,611,389	(69,172)	5,542,217			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(3,188)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	46,151	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,303)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(24,719)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(33,800)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(37,242)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (56,101)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(13,071)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (13,071)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (69,172)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Burgin Manor of Olney, Inc.

ID# **0026765**

Report Period Beginning: **01/01/04**

Ending: **12/31/04**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Expenses	$ (745)	20	1
2	Offset Interest Income	(13,854)	32	2
3	Offset Vending Machine Income	(3,643)	43	3
4	Offset Telephone Income	(1,689)	21	4
5	Newscoop	(5,355)	43	5
6	Public Relations	(4,994)	43	6
7	Golden Friendship	(715)	43	7
8	Resident/Family Relations	(2,828)	43	8
9	Coporate Taxes	(300)	43	9
10	Transfer Insurance	(3,119)	43	10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(37,242)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	568	0	0	0	0	0	0	0	0	0	568	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	568	0	0	0	0	0	0	0	0	0	568	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(36,066)	0	0	0	0	0	0	0	0	0	(36,066)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(745)	426	0	0	0	0	0	0	0	0	0	(319)	20
21	Clerical & General Office Expenses	(1,689)	7,002	0	0	0	0	0	0	0	0	0	5,313	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	2,000	0	0	0	0	0	0	0	0	0	2,000	27
28	**TOTAL General Administration**	(2,434)	(26,638)	0	0	0	0	0	0	0	0	0	(29,072)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(2,434)	(26,070)	0	0	0	0	0	0	0	0	0	(28,504)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	46,151	533	0	0	0	0	0	0	0	0	0	46,684	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(13,854)	3,387	0	0	0	0	0	0	0	0	0	(10,467)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	9,079	0	0	0	0	0	0	0	0	0	9,079	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	32,297	12,999	0	0	0	0	0	0	0	0	0	45,296	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(85,964)	0	0	0	0	0	0	0	0	0	0	(85,964)	43
44	**TOTAL Special Cost Centers**	(85,964)	0	0	0	0	0	0	0	0	0	0	(85,964)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(56,101)	(13,071)	0	0	0	0	0	0	0	0	0	(69,172)	45

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerold Axelbaum	30.58			Burgin Health		
Shirley Axelbaum	30.58			Management, Inc.	Unversity City, MO	Management Co.
Steven Axelbaum	9.71					
Bruce Axelbaum	9.71					
Richard Axelbaum	9.71					
David Axelbaum	9.71					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Management Fees	$ 187,189	Burgin Health Mangement, Inc.		$ 151,123	$ (36,066)	1
2	V	27	Miscellaneous		Burgin Health Mangement, Inc.		2,000	2,000	2
3	V	20	Taxes and Licenses		Burgin Health Mangement, Inc.		426	426	3
4	V	21	Clerical Expense		Burgin Health Mangement, Inc.		7,002	7,002	4
5	V	6	Maintenance		Burgin Health Mangement, Inc.		568	568	5
6	V	30	Depreciation		Burgin Health Mangement, Inc.		533	533	6
7	V	32	Interest		Burgin Health Mangement, Inc.		3,387	3,387	7
8	V	34	Rent		Burgin Health Mangement, Inc.		9,079	9,079	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 187,189			$ 174,118	$ * (13,071)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NA								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Burgin Health Management
Street Address: 8220 Delmar
City / State / Zip Code: University City, MO
Phone Number: (314-692-0777
Fax Number: (314-392-0406

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	20	Taxes and Licenses	Costs	5,421,200	1	$ 426	$	5,421,200	$ 426	1
2	21	Clerical Expense	Costs	5,421,200	1	7,002		5,421,200	7,002	2
3		Miscellaneous	Costs	5,421,200	1	2,000		5,421,200	2,000	3
4	30	Deprecaition	Costs	5,421,200	1	533		5,421,200	533	4
5	32	Interest	Costs	5,421,200	1	3,387		5,421,200	3,387	5
6	34	Rent	Costs	5,421,200	1	9,079		5,421,200	9,079	6
7	17	Management Fees	Driect Costs	5,421,200	1	151,123		5,421,200	151,123	7
8		Maintenance	Costs	5,421,200	1	568		5,421,200	568	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,118	$		$ 174,118	25

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	U.S. Bank		X	Mortgage	$3,100 + int.	10/4/02	$ 2,245,000	$ 2,152,009	10/4/07	libor+2.5%	$ 113,090	1
2												2
3												3
4												4
5												5
	Working Capital											
6	U.S. Bank		X	Operating	Interest	10/4/02	494,925	219,247	10/4/07	libor+2.5%	10,421	6
7	See Attachment		X	Various	Various	Various			Various	Various	3,433	7
8												8
9	TOTAL Facility Related						$ 2,739,925	$ 2,371,256			$ 126,944	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,739,925	$ 2,371,256			$ 126,944	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	77,254	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	73,238	2
3. Under or (over) accrual (line 2 minus line 1).	$	(4,016)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	73,238	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	69,222	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	74,315	8
2000	75,966	9
2001	77,133	10
2002	77,254	11
2003	73,238	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Accrual for 2004 Taxes=73238

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgin Manor of Olney, Inc. COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0026765

CONTACT PERSON REGARDING THIS REPORT Ms. Sue Bergin

TELEPHONE 618-395-1000 FAX #: 618-392-2150

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-06-35-350-001	See Attached	$ 28,384.06	$ 28,384.06
2.	1-06-35-350-002	See Attached	$ 44,853.58	$ 44,853.58
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 73,237.64	$ 73,237.64

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,617 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	234,725	1982	$ 75,000	1
2					2
3	TOTALS	234,725		$ 75,000	3

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1982	1982	$ 1,510,000	$	15	$ 53,929	$ 53,929	$ 1,215,289	4
5			1996	1996	826,743	21,199	39	33,070	11,871	245,352	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1985	557		10			557	9
10	Land Improvements			1987	21,035		10			21,035	10
11	Land Improvements			1991	622	36	15	41	5	469	11
12	Landscaping			1992	1,112	66	15	19	(47)	1,112	12
13	Asphalt Repairs			1995	455		10			455	13
14	Courtyard Improvements			1996	1,533	126	7	219	93	1,370	14
15	Additions			1983	35,819		10			35,819	15
16	Additions			1984	30,212		10			30,212	16
17	Additions			1985	14,744		10			14,744	17
18	Additions			1986	24,917		19			24,917	18
19	Additions			1987	16,810		10			16,810	19
20	Additions			1988	387		10			387	20
21	Additions			1989	10,163		10			1,163	21
22	Additions			1990	12,277		10			12,277	22
23	Additions			1991	28,943	919	31	931	12	16,971	23
24	Additions			1992	3,542	112	31	114	2	1,809	24
25	Additions			1993	51,504	1,398	Various	1,408	10	41,792	25
26	Additions			1994	36,243	1,188	Various	2,691	1,503	27,635	26
27	Additions			1994	4,406	11	Various	227	216	2,235	27
28	Additions			1995	7,326	73	Various	619	546	5,787	28
29	Additions			1996	87,605	3,893	Various	8,049	4,156	87,605	29
30	Landscaping			1997	2,287	133	15	152	19	1,313	30
31	Entrance Drive			1997	8,461	491	15	564	73	4,583	31
32	Lighting			1997	739	63	7	106	43	715	32
33	Fire Alarm			1997	1,316	112	7	188	76	1,269	33
34	Beds (used to say Sprinkler)			1997	30,726	2,612	7	4,389	1,777	27,850	34
35	Soffit			1998	16,899	433	39	433		2,377	35
36	Fencing			1998	15,209	932	15	1,014	82	5,576	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Landscaping	1998	$ 1,292	$ 79	15	$ 86	$ 7	$ 452	37
38	Parking Lot	1998	23,912	1,466	15	1,594	128	8,966	38
39	Lighting-West Building	1998	1,085	28	39	28		162	39
40	Lighting-East Building	1998	701	18	39	18		114	40
41	Ceiling-East Hall	1998	1,670	43	39	43		239	41
42	Carpet	1998	498	59	7	71	12	323	42
43	Door Closrs	1998	1,062	90	7	152	62	579	43
44	Lighting Improvements	1998	9,850	253	39	253		1,511	44
45	Carpet	1999	296	27	7	42	15	288	45
46	Hubl & Ratchet Cutter	1999	1,129		10	113	113	631	46
47	Carpet	1999	888	81	7	127	46	841	47
48	Sprinklers	1999	1,079		7	154	154	847	48
49	Sprinklers	1999	477		7	68	68	368	49
50	Electric Quick Serv	1999	435		10	44	44	242	50
51	Ceiling-West Nurse's Station	1999	531	14	39	14		156	51
52	Ceiling-Aspen	1999	1,221	31	39	31		348	52
53	Breezeway Soffit, Facia, and gutters	1999	1,435		15	96	96	504	53
54	Sidewalks	1999	10,278	716	15	685	(31)	3,711	54
55	Driveway	1999	19,536	1,365	15	1,302	(63)	6,836	55
56	Gutter	1999	(220)		15			30	56
57	Soffit	1999	(1,215)		15			162	57
58	Tools	1999	(435)		10			88	58
59	Ratchet Cutter	1999	(1,129)		10			226	59
60	Dry Pendant Sprinklers	1999	(1,556)		7			444	60
61	Concrete Pad for Dumpster Site	2000	906	70	15	60	(10)	300	61
62	Lamps	2000	5,502	687	7	786	99	3,428	62
63	Electrical Fixtures	2000	3,761	470	7	537	67	2,296	63
64	Alarm System	2000	10,261	1,282	7	1,466	184	6,450	64
65	Overbe Tables	2000	5,670	708	7	810	102	3,375	65
66	4 Drawer Cabinets	2000	19,256	2,406	7	2,751	345	10,821	66
67	Drapes, Valances, Bedspreads	2000	23,184	22,897	7	3,312	(19,585)	19,210	67
68	Sidewalks	2000	14,236	1,095	15	949	(146)	6,407	68
69	Chairs	2000	11,939	1,492	7	1,706	214	7,506	69
70	TOTAL (lines 4 thru 69)		$ 2,970,127	$ 69,174		$ 125,461	$ 56,287	$ 1,937,346	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,970,127	$ 69,174		$ 125,461	$ 56,287	$ 1,937,346	1
2	Remodeling	2000	8,255	1,031	7	1,179	148	4,637	2
3	Corner Protectors & Kick Plates	2000	2,873	287	10	287		1,435	3
4	Painting	2000	11,260	2,252	5	2,252		11,260	4
5	Floor Tiling	2000	3,799	475	7	543	68	2,009	5
6	Wall Paper	2001	10,972	2,194	5	2,194		10,970	6
7	3 Ceiling Fans	2001	1,359	49	27	50	1	200	7
8	Architectual Services	2001	12,131	441	27	449	8	1,797	8
9	Drywalling	2001	919	33	27	34	1	136	9
10	2 Bedrooms converted to dining room	2001	1,103	40	27	41	1	164	10
11	Drapery Liners & Hardware	2001	2,856	699	7	408	(291)	1,632	11
12	Floor Tiling	2001	11,118	1,945	7	1,588	(357)	6,352	12
13	Magnetic Lock & Key Pad	2001	2,872	503	7	410	(93)	1,640	13
14	2 60 lb Washers	2001	13,630		7	1,947	1,947	7,788	14
15	Toilet & Lavatory	2001	1,281	107	7	183	76	625	15
16	Alarm System	2001	5,903		7	84	84	3,372	16
17	2 Boilers for Furnance	2001	16,508	2,888	7	2,358	(530)	9,432	17
18	Doors for Aspen Wing	2001	981	172	7	140	(32)	560	18
19	Air Handler	2002	2,096	513	7	299	(214)	897	19
20	Smoke Detector	2002	1,440	353	7	206	(147)	618	20
21	Bathroom Flooring	2002	255	9	27	9		19	21
22	East Dining Room Flooring	2003	2,236	78	27	83	5	166	22
23	West Building Roof	2003	47,312	789	27	1,752	963	3,504	23
24	Aspen Lighting	2003	1,219		7	174	174	348	24
25									25
26	Roof on East Building	2004	36,916	615	27	1,367	752	1,367	26
27	Generator	2004	25,671	194	27	951	757	951	27
28	New Handrails in East Building	2004	3,252	44	27	120	76	120	28
29	Exterior Door for Laundry	2004	950	13	27	35	22	35	29
30	Medicare Wing Room Lights	2004	1,822	1,822	7	260	(1,562)	260	30
31	Difference	2004	5,517	5,517	1	5,517		5,517	31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,206,633	$ 92,237		$ 150,381	$ 58,144	$ 2,015,157	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 584,185	$	$ 1,484	$ 1,484		$	71
72	Current Year Purchases	13,934	13,934	2,125	(11,809)			72
73	Fully Depreciated Assets	377,659						73
74								74
75	TOTALS	$ 975,778	$ 13,934	$ 3,609	$ (10,325)		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residential Care	1992 Ford Ranger	1996	$ 3,780	$	$	$	5	$ 3,780	76
77	Facility Use	1993 Dodge	1997	3,000					3,000	77
78	Facility Use	2000 Ford Van	2000	42,810		8,562	8,562	5		78
79	Facility Use	1998 Toyota Avalon	2001	17,000		3,400	3,400			79
80	TOTALS			$ 66,590	$	$ 11,962	$ 11,962		$ 6,780	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,324,001	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 106,171	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 165,952	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 59,781	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,021,937	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Infiniti I-30 Acquired in 2002	$ 19,833	$ 2,950	$ 10,910	86
87	2004 Camry acquired in 2004	24,399	10,610	10,610	87
88					88
89					89
90					90
91	TOTALS	$ 44,232	$ 13,560	$ 21,520	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 15,329 Description: Dishwasher-$1140, IVAC Pump-$2613, O2 Concentrator-$10656, Pulse O2-$650, Misc-$270
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	3,425	$	170,874	$ 566	3,425	$ 171,440	1
2	Licensed Speech and Language Development Therapist		hrs		600		46,465		600	46,465	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		2,523		227,430	1,014	2,523	228,444	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	6,548	$	444,769	$ 1,580	6,548	$ 446,349	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 156,472	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	650,629		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	8,561		6
7	Other Prepaid Expenses	64,639		7
8	Accounts Receivable (owners or related parties)	415,043		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,295,344	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	3,118,490		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,128,465		16
17	Accumulated Depreciation (book methods)	(3,206,999)		17
18	Deferred Charges	228,695		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,343,651	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,638,995	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 150,623	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,170,373		29
30	Accrued Salaries Payable	132,457		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	73,238		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Liabilities	(958)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,525,733	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	341,963		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 341,963	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,867,696	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (228,701)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,638,995	$	48

***(See instructions.)**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (427,017)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (427,017)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	414,490	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(212,120)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Adjustment to Retained Earnings**	(4,054)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 198,316	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (228,701)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,921,616	1
2	Discounts and Allowances for all Levels	(2,818,821)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,102,795	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	562,652	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 562,652	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,706	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	3,188	15
16	Rental of Facility Space		16
17	Sale of Drugs	97,456	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	172,873	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 304,223	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,613	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,613	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	43,597	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 43,597	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,025,880	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,085,916	31
32	Health Care	2,790,274	32
33	General Administration	1,201,776	33
	B. Capital Expense		
34	Ownership	341,413	34
	C. Ancillary Expense		
35	Special Cost Centers	106,745	35
36	Provider Participation Fee	85,266	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,611,390	40
41	**Income before Income Taxes (line 30 minus line 40)****	414,490	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 414,490	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,051	2,191	$ 55,288	$ 25.23	1
2	Assistant Director of Nursing	2,073	2,289	52,824	23.08	2
3	Registered Nurses	31,212	33,331	601,241	18.04	3
4	Licensed Practical Nurses	15,327	16,121	246,941	15.32	4
5	Nurse Aides & Orderlies	99,454	103,482	951,088	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,059	3,294	35,794	10.87	8
9	Activity Director	2,049	2,183	30,223	13.84	9
10	Activity Assistants	10,049	10,352	75,813	7.32	10
11	Social Service Workers	2,097	2,212	22,024	9.96	11
12	Dietician					12
13	Food Service Supervisor	3,909	4,182	50,271	12.02	13
14	Head Cook	7,336	7,645	64,660	8.46	14
15	Cook Helpers/Assistants	17,478	18,080	121,449	6.72	15
16	Dishwashers					16
17	Maintenance Workers	5,071	5,259	62,608	11.90	17
18	Housekeepers	13,848	14,338	104,424	7.28	18
19	Laundry	10,303	10,563	81,179	7.69	19
20	Administrator	2,091	2,306	68,299	29.62	20
21	Assistant Administrator	1,582	1,684	26,770	15.90	21
22	Other Administrative					22
23	Office Manager	1,771	2,002	38,742	19.35	23
24	Clerical	3,858	4,066	47,393	11.66	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Dietary Nut. Aide	5,789	6,036	42,237	7.00	33
34	TOTAL (lines 1 - 33)	240,407	251,616	$ 2,779,268 *	$ 11.05	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	222	$ 10,673	Line 1(3)	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,607	Line 11(3)	44
45	Social Service Consultant	24	1,607	Line 12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	270	$ 13,888		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shirley Axelbaum	Administrative	30.58	$ 0
Sue Gurgin	Administrator	0	68,299
Una Tarpley	Asst. Admin.	0	26,770
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,069

B. Administrative - Other

Description	Amount
Management Fees (elminated in column 7)	$ 187,189
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 187,189

C. Professional Services

Vendor/Payee	Type	Amount
Rosenblum, Goldenhersch	Legal	$ 20
Blumenfield, Kaplan, Sandweiss	Legal	2,329
Weber & Hahn	Legal	655
Ray Vaughn	Legal	1,488
Cunningham Accounting Serv.	Accounting	8,977
Stone Carlie & Co.	Accounting	3,725
BKD, LLP	Accounting	6,600
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 23,794

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	166,420
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	9,217
Other Employee Benefits	444,055
TOTAL (agree to Schedule V, line 22, col.8)	$ 619,692

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	852
(Indicate # of checks performed 71)	
Various Books and Subscriptions	1,703
Quality Assurance	177
Other/Illinois Health Care Assn Dues	9,759
Less: Public Relations Expense	(745)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 11,746

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,823
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,823

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IHCA

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 7 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 40,016 Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 85,266
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? YES
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? YES If YES, please indicate the amount of income earned from such a program during this reporting period. $ 5,893
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.